

Dr. Russell Yancey, DDS

STATEMENT OF ANESTHESIA SERVICES

PHONE: (317) 459-0738

NPI# 1255622635

Tax ID# 83-4040548

NOTE TO INSURANCE CARRIERS:
Patient has paid this office in full for
anesthesia services.
(unless otherwise noted)
PLEASE REIMBURSE PATIENT



PATIENT Sample Bill for a 2 hour case DOB _____ DATE OF SERVICE _____

LOCATION OF ANESTHESIA SERVICES _____ DENTIST/SURGEON _____ SPECIALTY _____

PATIENT DIAGNOSIS

- ☐ E11.9 Diabetes, Type II, w/o comp
☐ F40.9 Phobic anxiety disorder
☒ F41.9 Anxiety disorder
☐ F79 Intellectual Disability
☐ F84.0 Autistic Disorder
☐ F90.1 ADHD
☐ F93.8 Anxiety/fearful child
☐ G40.909 Epilepsy
☐ G80.9 Cerebral Palsy
☐ I11.9 Hypertensive Heart Disease
☐ I25.2 Post Myocardial Infarction
☐ J45.909 Asthma
☐ R01.0 Benign and innocent cardiac murmur
☐ Other: _____

DENTAL DIAGNOSIS

- ☐ K00.1 Supernumerary tooth
☐ K00.6 Disturbance in eruption
☐ K01.1 Impacted teeth
☒ K02.9 Dental caries, unspecified
☐ K03.5 Ankylosis of teeth
☐ K04.0 Pulpitis
☐ K04.4 Acute apical periodontitis
☐ K05.30 Chronic periodontitis
☐ Other: _____

NOTES:

DOCTOR'S SIGNATURE _____

CPT	ADA	PROCEDURE	FEE
	D9210	Local anesthesia not in conjunction w/ operative or surgical procedures	_____
	D9211	Regional block anesthesia	_____
	D9212	Trigeminal division block anesthesia	_____
	D9215	Local anesthesia in conjunction w/ operative or surgical procedures	_____
	D9219	Preoperative Evaluation	<u>\$150</u>
	D9222	General Anesthesia – first 15 min	<u>\$150</u>
00170	D9223	General Anesthesia (ea. additional 15 min) <u>7</u> x \$150 =	<u>\$1,050</u>
	D9230	Analgesia, anxiolysis, inhalation nitrous oxide	_____
	D9239	Intravenous moderate (conscious) sedation/anesthesia first 15 minutes	_____
00170	D9243	Moderate Sedation (ea. additional 15 min) _____ x \$150 =	_____
	D9248	Non-intravenous conscious sedation	_____
	D9310	Consultation	_____
	D9610	Therapeutic parenteral drug, single admin.	_____
	D9612	Therapeutic parenteral drugs, two or more	<u>\$0</u>

TIME:

Anesthesia Time 2 Hours _____ Minutes

ASA Classification _____ ASA units _____ TOTAL FEE \$1,350

There is a **\$1000 minimum fee** for every pediatric case which is 2 hours or less and a **\$750 minimum fee** for every adult case which is 1 hour or less.

MEDICAID ID# _____